

North Carolina Department of Health and Human Services
Division of Health Benefits
Exondys 51 PA Request Form

Exondys 51

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Recipient Gender: _____

Prescriber Information

6. Prescribing Provider NPI#: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Med requested: **EXONDYS 51** 9a. Strength: _____ 9b. Quantity per 30 days _____
9c. Requested Duration (up to 6 months) _____ 9d. Beneficiary's weight _____
10. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? **YES** _____ **NO** _____
11. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 51 skipping? **YES** _____ **NO** _____
12. Is Exondys 51 being prescribed by or in consultation with a neurologist? **YES** _____ **NO** _____
13. Is the beneficiary taking any other RNA antisense agent or any other gene therapy?
YES _____ **NO** _____
14. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week?
YES _____ **NO** _____

For PA renewal

15. Is documentation attached that shows the beneficiary:
a. Has shown an improvement in dystrophin levels **or**
b. Is not ventilator dependent **or**
c. Has some functional use of upper extremities **or**
d. Has an ability to walk with or without assistive devices
YES _____ **NO** _____

Signature of Prescriber: _____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to NCTracks.

Fax all forms and lab work to NCTracks at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.